MEDICAL FLEXIBLE SPENDING PROGRAM (MEDFLEX) OPEN ENROLLMENT PLAN YEAR 2020

MEDFLEX

CO-1306 (Rev. 9/2019)

Office of the State Comptroller Healthcare Policy & Benefit Services Division

EMPLOYEE INFORMATION	Employee Name (last, first, middle initial)	Employee Number	Job Record Number
	Street Address	Date of Birth	Social Security Number (must be provided)
	City, State, Zip Code	Date of Hire	
	Employee Personal Email	Office Telephone No.	Home Telephone No.
	Gender □ Male □ Female	Marital Status ☐ Single ☐ Married	
	You CANNOT enroll in the MEDFLEX if you are:		
ELIGIBILITY	 On unpaid leave for any reason Adjunct faculty or graduate assistant Working or expected to work less than 0.5 full time equivalent (0.5 FTE) 		
ENROLLMENT INFORMATION	Annual Election Amount \$	I am paid on the fo	llowing Payroll Cycle:
	(Annual minimum is \$520 / Annual maximum is \$2,700)	☐ Bi-weekly (26) ☐ S	Semi-Monthly (24)
	☐ If IRS maximum changes during open enrollment, to	use	Five Pay (5)
	that amount check this box.	☐ Special bi-weekly (26)	
	Are you planning to retire during 2020? Yes No (If yes, insert month)		
	I elect to participate with the pre-paid debit card ☐ Yes ☐ No		
AUTHORIZATION	I certify that the above information is true and correct and that I will only use my MEDFLEX to pay for IRS-qualified expenses for myself and my eligible dependents during the plan year. I understand that I cannot deduct expenses reimbursed by my MEDFLEX on my federal tax return. I will retain documentation for claim substantiation.		
	I hereby authorize the State of Connecticut to reduce my gross salary, before federal, state and Social Security taxes are withheld by the total annual election amount indicated above and affirm my understanding that:		
	 My election cannot be changed during the plan year, unless I experience a qualifying change in family status, as defined by the Internal Revenue Code Section 125. Any election changes must be made within 31 days of and consistent with the change in status. MEDFLEX funds in excess of \$500 that are not claimed for eligible plan year expenses by March 31, 2021, will be forfeited in accordance with Internal Revenue Code requirements. 		
Employee Signature			Date

MAIL, E-MAIL OR FAX COMPLETED FORM TO:

Progressive Benefit Solutions, LLC (PBS) 14 Business Park Drive #8, Branford, CT 06405 Phone 1-866-906-8023 or 203-985-1712 FAX: 203-974-4898

Email: Enrollment@pbscard.com